State Employee Benefits Committee
June 28, 2010, 2:00 p.m.
Tatnall Building, Room 112
Dover, Delaware

The State Employee Benefits Committee met on June 28, 2010 at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, OMB, Director,
Statewide Benefits
Faith Rentz, OMB, Statewide Benefits
Ann Skeans, OMB, Statewide Benefits
Mary Thuresson, OMB, Statewide Benefits
Vicki Ford, OMB, Financial Operations
Casey Oravez, OMB, Financial Operations
Tina Hession, OMB, PHRST
Mike Morfe, AON Consulting
Mike Casey, AON Consulting
Carolyn Berger, Justice, Supreme Court
Tom Cook, Director, Department of Finance
Linda Nemes, Department of Insurance
Nick Adams, State Treasurer's Office
Crystal Webb, DHSS
Dave Craik, Office of Pensions
Elio Battiste, Department of Justice
Tom Chapman, Chair, SEBAC
Mike Nichols, SEBAC
Toni A. Reed, U of D
Peggy Teal, City of Dover
Judy Anderson, DSEA
Tim Barchak, DSEA
Jim Testerman, DSEA, retired
Karol Powers-Case, DRSPA
Mike North, Aetna
Julie Caynor, Aetna
Daniel Hohenberger, CEO, Coventry
Andrew Brancati, Blue Cross Blue Shield DE
Faith Joslyn, Blue Cross Blue Shield DE
Jay Reed, Blue Cross Blue Shield DE
John Kenyon, AFSCME
Joe Morocco, HMS
David Leiter, State Employee, DHSS
Richard Sharon
Jim Cannon, J & J

Agenda Items Discussed:

Introductions/Sign In

Ms. Visalli called the meeting to order at 2:05 p.m. Introductions around the room followed. Due to a needed revision of the prior meeting minutes, they would be presented later in the meeting.

Directors Report

Ms. Lakeman reported that every year during Open Enrollment employees must complete an updated Spousal Coordination of Benefits Form. On June 22nd the vendors' lists were received on those who had not done the form or those who were not compliant, meaning their spouse did not enroll in their employers plan if they offered one. There were 2,051 employees whose spouses will be sanctioned because they did not complete the form. There were 126 spouses who were not compliant with the policy out of just under 18,000 policies that cover spouses. Letters went out last Thursday. Calls and questions are being received at our office. The form can be updated at any time and the sanction will be lifted. Benefit coverage is usually retroactive once the form is updated.

Health Fund Financials – (Two handouts)

Ms. Ford explained the May 2010 Fund and Equity report. The net fund equity balance was a little over $2.5 million. The difference from the previous month was due to quarterly adjustments to claim liability. There were no questions.

Mr. Morfe presented the FY10 Third Quarter Financials. There was a premium moratorium of $20 million in the second quarter. The adjusted base for the year was about $25 million. The emerging trends were about 8 percent. Details for each quarter were reviewed. The 1st quarter showed the PPO actives as challenging. The 2nd quarter experience continued to deteriorate and the 3rd quarter balanced out the first two. Rates are back on line for where they were expected to be. Trends of 6 to 8 percent were expected to emerge. They are getting about 8 percent on a per contract basis and on a per member basis it is 6.8 to 7 percent. The high point is that early fiscal year poor experience for the PPO actives population has contained itself. Plans by vendor were reviewed. In summary, through the third quarter, the plan has ended on the high end of what was expected. There were no questions.

Update on Plan Changes Effective July 1, 2010

Ms. Lakeman stated that both of the health care carriers, Blue Cross and Aetna, have sent a list of those who are grandfathered for the IVF benefits to Medco. As of July 1, they will continue to have a $30,000 combined lifetime limit for IVF services as well as not have the 25 percent co-insurance applied to them. If there are questions from providers or members they will be handled at our office on a case by case basis. Those who were grandfathered were those who were approved for IVF prior to July 1 or had any type of services related to infertility including IVF after January 1, 2009.

Concerning Med Solutions, Blue Cross sent letters to members last week reminding them that the Hi Tech Radiology Imaging will be put in place as of July 1st, outlining member responsibility and provider responsibility. Providers will also be getting a letter applicable to what they should be doing when they request one of these tests. Information has been posted on our website.

Ms. Lakeman referred the Committee to the handout for Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Act was enacted on October 3, 2008 and since that date there has been additional guidance released. Details of the requirements were reviewed and how it applies to the State of Delaware plan as of July 1, 2010. The SEBC voted to adopt the mandate at the February 19, 2010 meeting with an estimated cost of $300K. The vote ensured that all in and out patient cost sharing, co-pays and treatment limits were equal under the mental health and medical/surgical plan benefits. This information was communicated to state employees and pensioners in the Open Enrollment booklet and on our web site.

Following the SEBC approval in February, the federal regulations for the MHPAEA were released in February 2010 and subsequent interpretation of these regulations was communicated to the Statewide Benefits Office late in May 2010.

The result is that the financial requirements or treatment limitations applied to mental health/substance abuse disorder benefits may not be more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits in the same classification. The definitions of predominant and substantially all and how the particular classifications were not as anticipated prior to the release of the regulations. The analysis could result in required cost sharing changes to be compliant. In addition, there were changes made by health care reform that remain unclear as to what changes can be made to a plan while still maintaining “grandfathered” status.

As a result of the regulations, some insurers requested a delay in the implementation date, which has not yet been granted by the federal government. Under the regulations, the State of Delaware can ask for an exemption until FY12 to be in compliance. Employees would have to be notified.

Based on our good faith effort to comply with intentions of MHPAEA, while keeping in mind efforts to minimize disruption post open enrollment and maintaining "grandfathered" status, the SEBC may wish to consider a motion to elect an exemption from the MHPAEA for FY11 which will be revisited prior to FY12 when the clear implication of the regulations and health care reform are available.

Justice Berger asked when this information was brought to our attention. Ms. Lakeman said the regulations were released in February but the interpretation and how it impacted our plan was not learned until the later part of May, a few days before the last meeting. There were still a couple of unclear, outstanding questions. Justice Berger asked for a summary of how this will impact state employees. Ms. Lakeman responded there would be no lack of benefits. All treatment limitations were removed. By the way services were aggregated, you had to look at all in-patient, in-network benefits together, not just comparing an in-patient hospital stay for medical/surgical and an in-patient hospital stay for mental health. It was more complex. When you look at out-patient in-network benefits, that's where we could have a problem when those are aggregated. It may require the Group Health Plan to shift some of the existing co-pays by raising some and decreasing others. We already made our decision for our 2011 plan year in terms of costs and implications, therefore, it is too late to change those now and not have an impact on our plan and on our grandfathered status. Justice Berger asked what effect it would have on somebody who is using this kind of health care if the plan takes the exemption. Ms. Lakeman stated it won't have any changes on the benefits that have been indicated to the employees. In other words, an out-patient in-network mental health visit will cost the same as an outpatient in-network visit for medical/surgical service. It's not hurting those members getting these services. Justice Berger asked if we have parity now and if we're going to keep it. Ms. Lakeman explained that we have parity as to how we interpreted the act before the regulations were released. The regulations require a more complex analysis of plan benefits, which would require the Group Health Plan to change certain out-patient co-pays, again increasing some and decreasing others in order to be fully compliant. We want to be absolutely sure of what we need to do and are asking for another year to do that. Justice Berger asked about any advance notice and noted that in February we said we were going for parity, right? Ms. Lakeman said correct, as it was understood at that time. Justice Berger clarified that everybody was told that and thought that would happen as of July 1. Ms. Lakeman agreed. Justice Berger wanted to know if she was correct in understanding that effective July 1st, the MHPAEA mandate was voted upon by the SEBC in February but did not account for the additional details provided by the later release of federal regulations and by the end of the fiscal year, we will do whatever the regulations require. Ms. Lakeman said they will revisit it again before FY12 to determine if we comply or if we should ask for another exemption. Everyone will have parity as per Delaware State Code and in accordance with the mandate as approved by the SEBC in February 2010. Ms. Visalli assured the committee that everything else that was thought to be necessary to comply has been done.

Mr. Adams asked if they made a motion and approved it today there wouldn't be any negative impact. Ms. Lakeman stated yes. Ms. Visalli said we could say this is our plan and adjustments could be made later if needed. Mr. Cook asked what consequences would be if we didn't ask for an exemption for one year. Ms. Lakeman explained that they would need to make some co-pay change which would impact some decisions employees may have made during open enrollment. Ms. Lakeman stated they needed a motion to request an exemption. Mr. Adams made the motion and Mr. Cook seconded the motion. Being no further questions and with a unanimous voice approval the motion carried.

Health Care Reform Updates – Mike Casey, Aon (handout)

Grandfathered Plan Guidance – June, 2010

Grandfathered Health Plans

- HHS, IRS and Department of Labor jointly issued interim final regulations regarding grandfathered health plans.
- Grandfathered plan status is determined separately with respect to each benefit package.
- Changes made before March 23, 2010, but effective later, do not impact Grandfathered status.
- Good faith change to comply with provisions before issuance of regulations will be considered if they modestly exceed provisions.

Loss of Grandfathered Plan Status

- A group health plan will lose grandfathered status if any of the following events occur:
    - Elimination of Benefits
    - Increase in Percentage Cost-Sharing Requirements (e.g. co-insurance)
    - Increase in Copayment Fixed Amount Cost-Sharing Requirements (can increase by $5)
    - Increase in Non-Copayment Fixed Amount Cost-Sharing Requirements (e.g. deductibles) cannot exceed approximately 20%
    - Decrease in Employer Contribution Rates (by more than 5%)
    - Changes in Annual Limits
    - Transfer of Employees (if it results in benefit changes that would otherwise lose grandfathered status)

Provisions Not Applicable to Grandfathered Plans

- Grandfathered health plans are not subject to health reform provisions regarding:
    - Preventive health services without any cost-sharing
    - Coverage of individuals participating in approved clinical trials
    - Essential health benefits package requirements
    - No prior authorization to select doctors for obstetrical care or for emergency services
    - Annual cost-sharing limits
    - Certain claims and appeals procedures

Provisions Applicable to Grandfathered Plans

- Coverage of adult children to age 26
- Waiting periods (maximum 90 days)
    - Delaware currently is first of the month after 90 days
- No lifetime or annual limits on essential health benefits
- Uniform explanation of coverage statements to participants

Effective Dates of applicable Provisions

	SEBC Effective Date
Coverage of adult children to age 26	FY12
Elimination of Waiting Periods	FY15
Elimination of Lifetime Limits	FY12
Elimination of Annual limits[1]	FY12
Uniform explanation of coverage statements to participants[2]	FY12

[1] Restricted annual limits on "essential health" benefits may be permitted until FY15.
[2] A statement that includes standardized summary of benefits and coverage information and written in a "culturally and linguistically appropriate" manner; provided with and in addition to annual enrollment materials.

There were no questions relating to the presentation.

SEBAC Comment

None.

Ms. Visalli informed officially this was Mr. Chapman's last SEBC meeting as chair of SEBAC. She enjoyed working with him, appreciated all his efforts and thanked him. Applaud followed.

Public Comments

Jim Testerman, DSEA retiree, explained how prior governors handled the state pension funds. A Pension Advisory Council was formed, which he has served on since 1976. He paid for his own health insurance until they lobbied the state to take over this function in the 1970's. Medical benefits were free at that time. Later he convinced legislators to provide a free supplement for Medicare. Over the years he's lobbied to improve the pension system and we have the best and the best funded pension system in the United States. Many employees make between $15 and $30K a year. The state has a good workforce because workers are trying to stay because of benefits. If the state wants to increase the cost of benefits to employees, then the salaries need to be greatly increased to match. For retirees with 30 years of service, with a pension slightly over 50 percent, an increase in medical is very hurtful. He will continue to work hard to prevent increased costs to employee and retiree benefits.

Dave Leiter, state employee, voiced his appreciation and thanks to Tom Chapman for his work and knowledge he gave the SEBAC. He is a great loss to the Council. In his opinion information that SEBAC gets is not comparable to what SEBC receives. He apologized for his confusion last month due to so much complex information.

Approval of Minutes

Ms. Visalli asked for the minutes to be reviewed. A revision on page five, paragraph three was noted. There being no comments or questions she asked for a motion to approve the minutes. Mr. Adams made the motion and Mr. Cook seconded the motion. The minutes were approved with a unanimous voice vote.

Other Business

Ms. Visalli stated the next SEBC meeting would be Monday, July 26th at 2:00 in the same room. The SEBC needed to go into Executive Session and there would be no further business for public session. If there was not other business she asked for a motion to go into Executive Session. Mr. Cook asked if she would give an update on the State budget and the Health Fund. Ms. Visalli explained that the Governor asked that an additional $37.5M be appropriated for the purposes of employee health benefits which had two components. One is to maintain, although rates are going up the employees will not have to bear any out of pocket cost this year. That rate increase won't be seen by employees until next year. Concerning the Reserve, this Committee made a motion when they approved the rates to use the Fund reserve if no additional funding was received through the State budget. From an actuarial standpoint such action was not advised. The Joint Finance Committee has upheld the recommendation of $37.5M. By June 30th, hopefully the money will be reserved. Mr. Cook noted the state was funding the employee increase this year. Next year they will be starting in the hole. They need to keep down utilization and make it affordable. Ms. Visalli explained on the health side there are three cost drivers, being: health care inflation; claims experience/utilization and plan design. They will continue to look for ways to contain expenses and not pass them to the state and employees. Other creative ways are being looked for, specifically in the areas of wellness and plan design. She asked for everyone to support these efforts by bringing forth ideas.

Ms. Visalli asked for a motion to end the public session to move into Executive Session. Mr. Cook made the motion and Mr. Adams seconded the motion. Upon unanimous voice approval the public session ended at 2:47.

At 3:23 p.m. the SEBC public session reconvened. Ms. Visalli asked for a motion on the health benefit appeal recommendation discussed in Executive Session. Mr. Adams made the motion and Mr. Cook seconded the motion. The motion carried upon unanimous voice approval.

Ms. Visalli asked for a motion to adjourn the meeting. Mr. Adams made the motion and Mr. Cook seconded the motion. The motion carried upon unanimous voice approval and the meeting ended at 3:24 p.m.

Respectfully submitted,

Mary K. Thuresson
Administrative Specialist
Statewide Benefits Office, OMB